Lakes Radiology

At Lakes Radiology *people* are the difference

WORKERS COMPENSATION OR CTP CLAIM - INFORMATION SHEET

Affix Patient Label

PATIENT DETAILS

Surname: _____ First Name: _____

Date of Birth: _____ Tel No: H: _____

Address: _____ W: _____

_____ M: _____

_____

Medicare Card No: _____

Date of Injury: _____ Injury Type: _____

Referring Doctor: _____

Examination Required: _____

EMPLOYER DETAILS:

Company Name: _____

Address: _____

Tel No: _____ Contact Person: _____

Occupation: _____

Have you informed your employer of this injury? Yes/No

INSURANCE COMPANY DETAILS:

Insurance Company: _____

Address: _____

Tel No: _____

Claim No: _____ Case Manager: _____

☐ I authorize Lakes Radiology to render a copy of the report of my examination to my employer and/or insurer

Patient Signature: …… Date: ……

Witness (Office Staff): …… Date: ……..

NOTE: NON Medicare Card Holders – in the event the insurer rejects this claim, you or your company will be invoiced at the AMA rate for the services rendered by Lakes Radiology